

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 15701

## CERTIFICATE OF DEATH

07255

Reg. Dist. No. 261

## 1. PLACE OF DEATH:

County... Somerset  
 City or town... Upper Fairmount, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Since Birth  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State... Maryland County... Somerset  
 City or town... Upper Fairmount  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Vernon Boyman

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

malewhite

6. (b) Name of husband or wife. 6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) December 11, 19438. AGE: Years Months Days If less than one day  
1 6 22 \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Upper Fairmount, Md.  
 (Town, county, and state)10. Usual occupation Child

11. Industry or business \_\_\_\_\_

12. Name Carroll Boyman13. Birthplace Cresfield, Ind.14. Maiden name Debra Virginia Miles15. Birthplace Marcus Hook, Tenn.16. Informant Carroll BoymanAddress Upper Fairmount, Md.17. Burial Date thereof July 5, 1945  
 (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory ManakinLocation Princess Anne, Md.18. Funeral director Harry MilesAddress Upper Fairmount, Md.19. 7/3 1945 Twelia D. Pearson  
 (Date read by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 2 1945 at 6 P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Birth 1943 to June 2 1945and that I last saw him alive on June 1 1945Immediate cause of death Acute D.O. Heart. Myocardial Infarction

## DURATION

1 YearDue to Myocardial InfarctionConstitutional

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE George C. Baillie

M. D. or other

Address Morris St. 220 Date signed July 3, 1945

RECEIVED  
JUL 12 1945  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age, is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 33

## CERTIFICATE OF DEATH

07256

Reg. Dist. No. 350

1. PLACE OF DEATH: Somerset  
County.....  
Crisfield  
City or town.....  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 6 hrs.  
Hospital, institution, or street address where death occurred:  
McCready Memorial Hospital  
How long in hospital or institution? 6 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State New York County.....  
City or town Brooklyn  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 1071 E. 37th Street  
(If rural, give LOCATION)  
2.(a) If veteran, name war.....

## 3.(a) FULL NAME

Carol Ann Bradshaw

## 3.(b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Single  
6.(b) Name of husband or wife.....  
6.(c) If alive, give age..... years  
7. Birth date of deceased (mo., day, yr.) January 23, 1939  
8. AGE: Years 6 Months 6 Days 23 hrs. min.

9. Birthplace Brooklyn, New York  
(Town, county, and state)  
10. Usual occupation.....  
11. Industry or business.....

FATHER 12. Name John Bradshaw  
13. Birthplace Brooklyn, New York  
MOTHER 14. Maiden name Helen Fahey  
15. Birthplace New York City, N. Y.

16. Informant Mrs. Helen Wright  
Address Cedar Street, Pocomoke City, Md.

17. Removal July 31, 1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Johns Cemetery  
Location Brooklyn, New York

18. Funeral director Walter B. Cooke, Inc.,

Address 1218 Flatbush Avenue, Brooklyn, N. Y.

19. July 29, 1945 Anne E. White  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 28, 1945, at 11:10 P.M.  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 28, 1945, to July 28, 1945, and that I last saw her alive on July 28, 1945.

Immediate cause of death Cause of death?  
DURATION

Due to Influenza, Meningitis?

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE George B. Carls, M.D.  
M. D. or other

Address Marion D. one Date signed July 29, 1945

RECEIVED  
AUG 7 1945  
BUREAU V.E.

AUG 7 1945  
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48-P)

## CERTIFICATE OF DEATH

07257

★ Reg. Dist. No. 265

## 1. PLACE OF DEATH:

County Somerset  
 City or town Barnfield  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 20 yrs  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Somerset  
 City or town Barnfield  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 136 S. Fourth  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war

## 3. (a) FULL NAME

Mary Emma Collins

## 3. (b) Social Security Number

316-07-7002

4. Sex Female 5. Color or race Colored 6. (a) Single, married, widowed, or divorced single  
 6. (b) Name of husband or wife  
 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) oct 9-1897  
 8. AGE: Years 47 Months 9 Days 6 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Marion Somerset Co Md  
 (Town, county, and state)  
 10. Usual occupation seafood worker  
 11. Industry or business

12. Name Noah Collins  
 13. Birthplace Somerset Co  
 14. Maiden name Mary E. Whittington  
 15. Birthplace Marion Somerset Co

16. Informant Larry Boyer  
 Address 136 S. Fourth St Barnfield Md  
 17. buried Date thereof july 18 1945  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Waymans  
 Location Marion Md  
 18. Funeral director E. H. Ward  
 Address Marion Md.

19. 7/17/45 19 45  
 (Date rec'd by registrar) Registrar C. E. Collins Md

## MEDICAL CERTIFICATION

20. DATE OF DEATH july 15 19 45, at 6:20 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 14 19 45 to July 15 19 45 and that I last saw him alive on July 14 19 45

Immediate cause of death congestion of lungs DURATION 18 mos

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. N. Boyton M.D. M. D. or other

Address 136 S. Fourth St Barnfield Md Date signed July 17

RECEIVED

JUL 27 1965

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1700

## CERTIFICATE OF DEATH

Reg. Diat. No. 260

## 1. PLACE OF DEATH:

County SomersetCity or town Princess Anne  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED.

(For newborn infants, give residence of mother)

State Maryland County SomersetCity or town Princess Anne  
(If outside city or town limits, write RURAL and give nearest town)Street No. Beechwood Street  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Robert Worthington Collier

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

white

## 6. (a) Single, married, widowed, or divorced

married

## 6. (b) Name of husband or wife

Margaret Gene Collier6. (c) If alive, give age 20 years

## 7. Birth date of

deceased (mo., day, yr.)

July 29 - 1921

## 8. AGE:

Years

Months

Days

If less than one day

23231210

hrs.

min.

## 9. Birthplace

Penn.

(Town, county, and state)

## 10. Usual occupation

Truck driver

## 11. Industry or business

MOTHER FATHER

## 12. Name

## 13. Birthplace

## 14. Maiden name

## 15. Birthplace

## 16. Informant

Address

## 17. (Burial, cremation, or inquest. Which?)

Date thereof

(month) (day) (year)

## Cemetery or crematory

## Location

## 18. Funeral director

Address

July 11, 1945

19

45

Rd.

John M. D.

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 10 1945 at 11:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him 10 to 19Immediate cause of death Broken neck & otherinjuries

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 7/10/45Where did injury occur? Princess Anne Somerset (City or town) (County) (State)Injured at home, farm, industry, public place (where?) Public placeMeans of injury Motor Vehicle accident Injured at work?23. SIGNATURE Henry S. Coulford M.D. M. D. or otherAddress Princess Anne Md Date signed 7/11/45

RECEIVED  
JUL 12 1945  
BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

07259



Reg. Dist. No.

269

## 1. PLACE OF DEATH:

County SomersetCity or town Monie  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life time

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County SomersetCity or town Monie Md  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3.(a) FULL NAME

Katie Washington Davis

## 3.(b) Social Security Number

## 4. Sex

Female

## 5. Color or race

White

## 6.(a) Single, married, widowed, or divorced

Married6.(b) Name of husband or wife Kirby Davis7. Birth date of deceased (mo., day, yr.) Feb. 17, 18716.(c) If alive, give age 7 years8. AGE: Years 74 Months 4 Days 20 It less than one day — hrs. — min.9. Birthplace Monie  
(Town, county, and state)10. Usual occupation House duties

11. Industry or business

12. Name Robert Ross13. Birthplace Yerquina (lost name)14. Maiden name Kittie (not known)15. Birthplace Monie Md.16. Informant Kirby DavisAddress Monie Md17. Burial Date thereof July 10-

(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory G.O.A.M.Location Oriskany Md18. Funeral director EdwardsAddress Deals Island Md19. July 10 19 45 Dr. D. Bennett

(Date recd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 7<sup>th</sup> 19 45, at \_\_\_\_\_ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ 19 \_\_\_\_\_, to \_\_\_\_\_ 19 \_\_\_\_\_

and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19 \_\_\_\_\_

Immediate cause of death Complicationsof a Cerebral Hemorrhageabout 3 years ago

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Chronic Hypertension

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE J. Smith M. D. or otherAddress Baltimore Md Date signed 7/10-45

RECEIVED  
JUL 20 1945  
BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

★ Reg. Dist. No. 270

## 1. PLACE OF DEATH:

County **Somerset**  
 City or town **Crisfield RURAL**  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

5 da

Hospital, institution, or street address where death occurred:

**McCreedy Memorial Hospital**

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State **Md** County **Somerset**City or town **Kingston**  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

**Bertha Pearl Gardinier**

## 3. (b) Social Security Number

## 4. Sex

**Female**

## 5. Color or race

**White**

## 6. (a) Single, married, widowed, or divorced

**Married**

## 6. (b) Name of husband or wife

**Robert Gardinier**

## 7. Birth date of deceased (mo., day, yr.)

**May 21 1921**

6. (c) If alive, give age \_\_\_\_\_ years

## 8. AGE:

Years **24**Months **1**Days **24**

If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

## 9. Birthplace

**Kingston Somerset Maryland**  
(Town, county, and state)  
**Housewife**

## 10. Usual occupation

## 11. Industry or business

## FATHER

## 12. Name

**James T Foster**

## 13. Birthplace

**Salem N C**

## MOTHER

## 14. Maiden name

**Laura Watson**

## 15. Birthplace

**N C**

## 16. Informant

**Robert Gardinier**

## Address

**Kingston Md**

## 17. Burial

(Burial, cremation, or removal. Which?)

Date thereof **July 18 1945**  
(month) (day) (year)

## Cemetery or crematory

**Rehoboth Presby. cemetery**

## Location

**Rehoboth Md**

## 18. Funeral director

**H Harvey Bradshaw**

## Address

**Crisfield Md**

## 19.

**7/18** 19**45**  
(Date rec'd by registrar)

## 19.

**Teresa P. Lawson**  
**E. E. Collins** Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH **July 15** 19**45**, at **34** M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

**July 11** 19**45** to **July 15** 19**45**  
and that I last saw him alive on **July 15** 19**45**

Immediate cause of death

**Shock. Acute Dec 7th**

DURATION

Due to

**Cerebral Embolism**  
**Intake of Stramonium**

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

**Abdomen filled & ruptured**  
**liver & coats (P. 1st.)** Date of op. **July 12 45**

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE

**Teresa P. Lawson**  
M. Doer other \_\_\_\_\_  
Address **Lawson St. Md** Date signed **July 17 45**

RECEIVED  
JUL 25 1945  
BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

07261

Reg. Dist. No. 260

## 1. PLACE OF DEATH:

County SomersetCity or town Orisle  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County SomersetCity or town Orisle  
(If outside city or town limits, write RURAL and give nearest town)Street No. ....  
(If rural, give LOCATION)

2.(a) If veteran, name war .....

## 3. (a) FULL NAME

William Henry Krick

## 3. (b) Social Security Number

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Daisy Krick

7. Birth date of

deceased (mo., day, yr.)

March 6 18846. (c) I alive, give age 59 years

8. AGE:

Years

Months

Days

If less than one day

61424

hrs.

min.

9. Birthplace

Barnersville, Pa.  
(Town, county, and state)

10. Usual occupation

carpenter

11. Industry or business

carpenter

FATHER

12. Name

Wm. Henry Krick

13. Birthplace

Barnersville, Pa.

MOTHER

14. Maiden name

Gertrude Baker

15. Birthplace

Barnersville, Pa.

16. Informant

Mrs. Robert Hall

Address

Orisle, Md.

17.

(Burial, cremation, or removal, Which?)

Date thereof

July 31 1945  
(month) (day) (year)

Cemetery or crematory

F. O. A. M. Cemetery

Location

Orisle, Maryland

18. Funeral director

Walter Washburn

Address

Princess Anne, Md.

(Date rec'd by registrar)

July 30, 1945 R. B. Johnson, M.D.

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 29 19 45 at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug. 3 19 44 to July 20 19 45and that I last saw him alive on July 20 19 45

Immediate cause of death

Carcinoma of stomach

DURATION

1 year

Due to .....

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. ....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. .... Date of .....

Where did injury occur? ....  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? .....

23. SIGNATURE

Frank M. ...

M. D. or other

Address ..... Date signed 8/4/45

RECEIVED  
AUG 7 1946  
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B12)

## CERTIFICATE OF DEATH

07262

Reg. Dist. No. 261

## 1. PLACE OF DEATH:

County **Somerset**  
 City or town **RURAL, Marion**  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? **89 years**  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State **Maryland** County **Somerset**  
 City or town **RURAL, Marion**  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. **Rt. # 1**  
 (If rural, give LOCATION)  
 2(a) If veteran, name war

## 3. (a) FULL NAME

**Robert Joseph Maddox**

## 3. (b) Social Security Number

4. Sex **Male** 5. Color or race **White** 6. (a) Single, married, widowed, or divorced **Widowed**  
 6. (b) Name of husband or wife **Effa Tenah Maddox**  
 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) **May 28, 1886**  
 8. AGE: Years **89** Months **1** Days **27** It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace **Quindocqua-Somerset-Maryland**  
 (Town, county, and state)

10. Usual occupation **Farmer**11. Industry or business **Truck farms**12. Name **Benjamin Simpson Maddox**13. Birthplace **Quindocqua, Maryland**14. Maiden name **Elizabeth Holland**15. Birthplace **Fairmount, Maryland**16. Informant **Vernon Maddox**Address **Marion, Maryland Rt # 1**

17. Burial **Burial** Date thereof **July 27, 1975**  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory **St Pauls Cemetery**Location **RURAL, Marion, Maryland**18. Funeral director **H. Harvey Bradshaw**Address **Crisfield, Maryland**19. **7/27** 19 **45**  
 (Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH **July 25** 19 **45**, at **10:30 P.M.**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **July 1** 19 **45**, to **July 25** 19 **45**, and that I last saw him **alive** on **July 25** 19 **45**.

Immediate cause of death

**Arteriosclerosis**

DURATION

Due to **Chronic Int. Nephritis****Chronic myocarditis**Due to **General Arterio Sclerosis**

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE **George C. Paulman**

M. D. or other

Address **Marion, MD** Date signed **July 26, 1975**

RECEIVED

AUG 2 1945

BUREAU V.S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 460

07263

## CERTIFICATE OF DEATH

Reg. Dist. No. 260

## 1. PLACE OF DEATH:

County SomersetCity or town Mt Vernon, Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County SomersetCity or town Mt Vernon, Md.  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2. (a) if veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Clifford Mc Intyre

## 3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Ethel Mc Intyre

7. Birth date of deceased (mo., day, yr.)

Sept. 29 1896

6. (c) If alive, give age \_\_\_\_\_ years

8. AGE:

Years

Months

Days

If less than one day

489hrs.min.

9. Birthplace

Mt Vernon, Md.  
(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

FATHER

12. Name

James Mc Intyre

13. Birthplace

Mt Vernon, Md.

MOTHER

14. Maiden name

George Anna Jones

15. Birthplace

Mt Vernon, Md.

16. Informant

Mrs Ethel Mc Intyre

Address

Mt Vernon, Md.

17.

(Burial, cremation, or removal, Which?)

Date thereof

July 23 1945  
(month) (day) (year)

Cemetery or crematory

Episcopal Cemetery

Location

Mt Vernon, Md.

18. Funeral director

Walter Washfield

Address

Princess Anne, Md.

19.

(Date received by registrar)

19 45W. A. Johnson Jr.

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 21 19 45 at 6:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 25 19 45 to July 20 19 45and that I last saw him alive on July 20 19 45

Immediate cause of death

Carcinoma of Jaw

DURATION

1 year

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury

Injured at work?

23. SIGNATURE

Frank Mat... M. D. on otherAddress Princess Anne Date signed July 23

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
JUL 31 1945  
BUREAU V. B.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1872

07264

## CERTIFICATE OF DEATH

★ Reg. Dist. No. 265

1. PLACE OF DEATH: Somerset  
County Crisfield  
City or town (If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? life  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
Maryland Somerset  
State County  
City or town Crisfield  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Maryland Ave.  
(If rural, give LOCATION)  
2(a) If veteran, name war none

### 3. (a) FULL NAME

Emma C. Mitchell

3. (b) Social Security Number  
none

4. Sex female 5. Color or race white 6. (a) Single, married, widowed, or divorced widow

6. (b) Name of husband or wife Orland L. Mitchell

7. Birth date of deceased (mo., day, yr.) May 18, 1865 8. (c) If alive, give age years

8. AGE: Years 80 Months 1 Days 13 If less than one day hrs. min.

9. Birthplace Crisfield, Md.  
(Town, county, and state)

10. Usual occupation Housewife Home

11. Industry or business

12. Name Annais Crockett 13. Birthplace Accomac Co., Va.

14. Maiden name Sally Riffin 15. Birthplace Md.

18. Informant Orland L. Mitchell DeBois Pa.  
Address

17. Burial Date thereof July 3/45  
(Burial, cremation, or removal. Which) (month) (day) (year)

Cemetery or crematory Family Burial Grds.

Location Crisfield, Md.

Howard H. Hubbard

18. Funeral director 306 Main St., Crisfield, Md.  
Address

19. 7/2/45 19. E. E. Collins M.D.  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH July 1/45 19 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1944 to July 1945  
and that I last saw him alive on July 1945

Immediate cause of death Coronary Artery Disease

Due to Hypertension

Due to Cardiac Vascular Renal Disease

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Chas. D. Schmetke

Address Crisfield Md Date signed July 1/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 25 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 176-2

07265

## CERTIFICATE OF DEATH

Reg. Dist. No. 260

## 1. PLACE OF DEATH:

County Princess AnneCity or town Sumner  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County WicomicoCity or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)Street No. 420 Oak Hill Ave  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Gillie Ellen Nettlet

## 3. (b) Social Security Number

## 4. Sex

female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

single

6. (b) Name of husband or wife

## 7. Birth date of deceased (mo., day, yr.)

Aug. 24, 1924

6. (c) If alive, give age..... years

## 8. AGE:

Years

Months

Days

If less than one day

20108

hrs.

min.

## 9. Birthplace

Salisbury, Delaware  
(Town, county, and state)

## 10. Usual occupation

## 11. Industry or business

## FATHER

## 12. Name

John W. Nettlet

## 13. Birthplace

Wheatonville, Md.

## MOTHER

## 14. Maiden name

Sarah Conway

## 15. Birthplace

Wheatonville, Md.

## 16. Informant

Mr. Sarah Nettlet

## Address

420 Oak Hill Ave. Salisbury, Md.

## 17

Buried  
(Burial, cremation, or removal. Which?)

## Date thereof

July 14-45  
(month) (day) (year)

## Cemetery or crematory

Parson's Cemetery

## Location

Salisbury, Maryland

## 18. Funeral director

Hallmay Co. Walter R. Hallmay

## Address

Salisbury, Maryland

## 19

July 11, 45

(Date rec'd by registrar)

R. D. Johnson

(Signature of registrar)

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

July 10, 1945

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19..... to ..... 19.....

and that I last saw him ..... alive on ..... 19.....

## Immediate cause of death

Broken neck & other injuries

## DURATION

## Due to

## Due to

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op. ....

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 7/10/45Where did injury occur? Princess Anne Sumner Md  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) Public placeMeans of injury Auto accident Injured at work? NoSignature Henry M. Loutford M.D.Address Princess Anne, MdDate signed 7/10/45

RECEIVED  
JUL 12 1945  
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 265

## 1. PLACE OF DEATH:

County Somerset

City or town Crisfield  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Somerset

City or town Crisfield  
(If outside city or town limits, write RURAL and give nearest town)Street No. Maryland Ave  
(If rural, give LOCATION)

2(a) If veteran, name war none

## 3. (a) FULL NAME

Norman N. Nock

## 3. (b) Social Security Number

4. Sex male

5. Color or race white

6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Ruth Nock

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 23, 1889

8. AGE: Years 55 Months 10 Days 1 It less than one day hrs. min.

9. Birthplace Crisfield, Md.  
(Town, county, and state)

10. Usual occupation Automobile mechanic

11. Industry or business Sterling Tawes Motor Co.

12. Name John W. Nock

13. Birthplace Md.

14. Maiden name Theresa A. Stewart

15. Birthplace Md.

16. Informant Raymond Woodland

Address Crisfield, Md.

17. burial Date thereof 7/26/45

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Family Burial Grds.

Location Crisfield, Md.

Howard H. Hubbard

18. Funeral director 306 Main St., Crisfield, Md.

Address

19. 7/25/45 C.E. Collins M.D.

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 24, 1945 at 11:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 24, 1945 to July 24, 1945

and that I last saw him alive on July 20, 1945

Immediate cause of death pneumonia

DURATION

Due to Carcinoma of the

Due to Esophagus Cancer

Due to Metastasis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Chas. P. Schwatka

Address Crisfield Date signed 7/25/45

RECEIVED

AUG 11 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18-2

## CERTIFICATE OF DEATH



Reg. Dist. No. 07267 262

## 1. PLACE OF DEATH

County Somerset  
 City or town Rural Pocomoke  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 22 years  
 Hospital, institution, or street address where death occurred: —  
 How long in hospital or institution? —

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Somerset  
 City or town Rural Pocomoke City, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. —  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war —

## 3.(a) FULL NAME

Emma Cecilia Paradee

## 3.(b) Social Security Number

—

## 4. Sex

Female

## 5. Color or race

white

## 6.(a) Single, married, widowed, or divorced

widowed

## 6.(b) Name of husband or wife

John L. Paradee

## 6.(c) If alive, give age

years

## 7. Birth date of deceased (mo., day, year)

February 16, 1853

## 8. AGE:

92 Years 5 Months 10 Days — hrs. — min.

## 8. Birthplace

Pocomoke, Somerset, Maryland

## 10. Usual occupation

Housewife

## 11. Industry or business

—

## FATHER

12. Name Zora Babel Smullin

## 13. Birthplace

Maryland

## MOTHER

14. Maiden name Mary A. Stewart

## 15. Birthplace

Maryland

## 16. Informant

Mrs. Harry Shaw

## Address

Rural Pocomoke Md.

## 17. Burial

Presbyterian Ch.

## Cemetery or crematory

Pocomoke Md.

## Location

Margaret St. Watson

## 18. Funeral director

Pocomoke Md.

## Address

—19. July 30 1945  
(Date rec'd by registrar)Imo Clayton Hanco  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 1945 at 2:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 24 1945 to July 24 1945 and that I last saw him alive on July 24 1945  
 Immediate cause of death Chronic Myocarditis

## DURATION

1 1/2

## Due to

## Due to

## Other conditions

Weakness by a fall  
in April 1945  
(Include pregnancy within 8 months of death)

## Major findings of operations

—

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

## Where did injury occur?

(City or town) (County) (State)

## Injured at home, farm, industry, public place (where?)

## Means of injury

Injured at work? —

## 23. SIGNATURE

N. E. Santorus  
M. D. or otherAddress Pocomoke City Md. Date signed 7/26/45

RECEIVED

JUL 31 1945

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 462

07269

## CERTIFICATE OF DEATH



Reg. Dist. No. 261

## 1. PLACE OF DEATH:

County... **Somerset**  
 City or town... **Marion RUAL**  
 (If outside city or town limits, write RUAL and give nearest town)  
 How long in above place of death? **77 yrs**  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State... **Md** County... **Somerset**  
 City or town... **Marion RUAL**  
 (If outside city or town limits, write RUAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

**Walter Joseph Price**

## 3. (b) Social Security Number

4. Sex **Male** 5. Color or race **White** 6.(a) Single, married, widowed, or divorced **Married**

6.(b) Name of husband or wife **Maggie Price**  
 6.(c) If alive, give age **64** years

7. Birth date of deceased (mo., day, yr.) **Nov 27 1867**

8. AGE: Years **77** Months **7** Days **20** If less than one day  
 hrs. min.

9. Birthplace **Marion, (RUAL) Somerset, Md.**  
 (Town, county, and state)

10. Usual occupation **Farmer**

11. Industry or business

FATHER 12. Name **Isaac Price**  
 13. Birthplace **Somerset County Md**

MOTHER 14. Maiden name **Annie Stevens**  
 15. Birthplace **Somerset County Md**

16. Informant **Mrs Annie Price**  
 Address **Marion Md**

17. Burial Date thereof **July 19 1945**  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory **Rehoboth Baptist Cemetery**  
 Location **Rehoboth Md**

18. Funeral director **H Harvey Bradshaw**  
 Address **Crisfield Md**

19. **7/19** **45** **Quedia P. L. L. L.**  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH **July 15** 19**45**, at **4 A** M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **July 16** 19**45** to **July 17** 19**45**; and that I last saw him alive on **July 16** 19**45**

Immediate cause of death **Heart** DURATION **4 yrs**

Due to **Chronic heart** **3 years**

Due to **Chronic heart**

Other conditions **Circumstances of Death** with

(Include pregnancy within 3 months of death)

Major findings of operations **none** Date of op. ....

Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide. Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE **Quedia P. L. L. L.** M. D. on other  
 Address **Marion Md** Date signed **July 19 1945**

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
JUL 21 1945  
BUREAU V.B.

Evidence for change of  
age of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1912

07268

270

FILM NO. G 97 JUL 27 1945

CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH:

County Summit  
City or town Crisfield md.  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 2 days  
Hospital, institution, or street address where death occurred:  
Mrs. E. C. C. Memorial Hosp.  
How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County Summit  
City or town Rehoboth md.  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. ....  
(If rural, give LOCATION)  
2. (a) If veteran, name war .....

3. (a) FULL NAME

Glenn O. Purney

3. (b) Social Security Number

✓

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
<u>male</u>	<u>white</u>	<u>married</u>
6. (b) Name of husband or wife <u>Elizabeth Purney</u>		
6. (c) If alive, give age <u>38</u> years		
7. Birth date of deceased (mo., day, yr.) <u>August 10, 1907</u>		
8. AGE:	Years	Months
<u>37</u>	<u>36</u>	<u>8</u>
	Days	If less than one day
	<u>10</u>	hrs. min.
9. Birthplace <u>Oakland Maryland</u> (Town, county, and state)		
10. Usual occupation <u>Farming</u>		
11. Industry or business		
FATHER	12. Name <u>Unknown</u>	
MOTHER	13. Birthplace <u>Unknown</u>	
	14. Maiden name <u>Unknown</u>	
	15. Birthplace <u>Unknown</u>	

16. Informant <u>Mrs. Elizabeth Purney</u>	Address <u>Rehoboth md.</u>	
17. <u>Burial</u>	Date thereof <u>July 6, 1945</u> (Burial, cremation, or removal. Which?) (month) (day) (year)	
Cemetery or crematory <u>Summit Ridge Memorial Park</u>	Location <u>Rural Crisfield md.</u>	
18. Funeral director <u>Margaret H. H. H.</u>	Address <u>Rehoboth md.</u>	
19. <u>7/5</u>	19 <u>45</u> <u>Jurcia P. Lawson</u> (Date rec'd by registrar) (month) (day) (year) Registrar	

MEDICAL CERTIFICATION

20. DATE OF DEATH <u>July 4, 1945</u>	at <u>Rehoboth md.</u>
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>July 1, 1945</u> to <u>July 4, 1945</u> and that I last saw him alive on <u>July 4, 1945</u>	
Immediate cause of death <u>Acute Del. of Heart</u>	DURATION
Due to <u>Cerebral</u>	
Due to <u>Acute Del. of Heart</u>	
Other conditions <u>Chronic Del. of Heart</u> <u>Chronic myocarditis</u> (Include pregnancy within 8 months of death)	
Major findings of operations .....	Date of op. ....
Autopsy results .....	
PHYSICIAN: Please underline the cause to which death should be charged statistically.	
22. VIOLENCE: If death was due to external causes, fill in the following:	
Accident, suicide, or homicide .....	Date of .....
Where did injury occur? .....	(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....	
Means of injury .....	Injured at work?
23. SIGNATURE <u>Glenn O. Purney</u>	M. D. or other
Address <u>Rehoboth md.</u>	Date signed <u>July 5, 1945</u>

MARGIN RESERVED FOR BINDING

V5 A15

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 25 1945

BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 702

## CERTIFICATE OF DEATH

Reg. Dist. No. 87270 260

## 1. PLACE OF DEATH:

County SomersetCity or town Princess Anne, Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County SomersetCity or town   
(If outside city or town limits, write RURAL and give nearest town)Street No.   
(If rural, give LOCATION)2.(a) If veteran, name war 

## 3. (a) FULL NAME

Marion F. Stacy

## 3. (b) Social Security Number

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced Divorced6.(b) Name of husband or wife 6.(c) If alive, give age  years7. Birth date of deceased (mo., day, yr.) Feb. 13, 19078. AGE: Years 38 Months 4 Days 28 If less than one day  hrs.  min.9. Birthplace Buwalde Md.  
(Town, county, and state)10. Usual occupation Seaman

## 11. Industry or business

FATHER 12. Name Poland Stacy13. Birthplace Buwalde, Md.MOTHER 14. Maiden name Maggi Arvey15. Birthplace Buwalde Md.16. Informant Ernest StacyAddress Princess Anne Md.17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof July 13, 1948  
(month) (day) (year)Cemetery or crematory St. Paul CemeteryLocation Crossfield Maryland18. Funeral director Wale WashfieldAddress Princess Anne Md.July 13, 45 Ralph Stacy, M.D.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 10 1945 at 11:45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 to 19and that I last saw him alive on 19

Immediate cause of death

DURATION

Profound shock & otherDue to injuries

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 7/10/45Where did injury occur? Princess Anne Md. (City or town) (County) (State)Injured at home, farm, industry, public place (where?) Public placeMeans of injury Auto accident Injured at work? No23. SIGNATURE Henry M. Lufford M.D.

M. D. or other

Address Princess Anne Md. Date signed 7/21/45

REC'D  
JUL 13 1945  
BUREAU A.B.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 07271 270

### 1. PLACE OF DEATH:

County.....**Somerset**  
City or town.....**Crisfield**  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?.....**86 years**  
Hospital, institution, or street address where death occurred:  
**McCready Memorial Hospital**  
How long in hospital or institution?.....**1 week**

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State.....**Maryland** County.....**Somerset**  
City or town.....**Crisfield**  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.....**Lawsonia**  
(If rural, give LOCATION)  
2.(a) if veteran, name war.....

### 3.(a) FULL NAME

**Isaac Tubman Sterling**

### 3.(b) Social Security Number

4. Sex.....**Male**  
5. Color or race.....**White**  
6.(a) Single, married, widowed, or divorced.....**Widowed**

6.(b) Name of husband or wife.....**Lillie Sterling**

7. Birth date of deceased (mo., day, yr.).....**December 24, 1858**  
6.(c) If alive, give age..... years

8. AGE: Years.....**86** Months.....**6** Days.....**19**  
If less than one day..... hrs. .... min.

9. Birthplace.....**Crisfield-Somerset-Maryland**  
(Town, county, and state)

10. Usual occupation.....**Sea Food Dealer**

11. Industry or business.....**Oysters & Crabs**

FATHER 12. Name.....**Edward Sterling**  
13. Birthplace.....**Crisfield, Maryland**

MOTHER 14. Maiden name.....**Sallie Milligan**  
15. Birthplace.....**Fairmount, Maryland**

16. Informant.....**Mrs. J. C. W. Tawes**  
Address.....**Crisfield, Maryland**

17. Burial Date thereof.....**July 15, 1945**  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory.....**Lawsonia Cemetery**  
Location.....**RURAL, Crisfield, Maryland**

18. Funeral director.....**H. Harvey Bradshaw**  
Address.....**Crisfield, Maryland**

19. **7/15/45** 19.....**6 E. Collins M.D.**  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH.....**July 13, 1945** at.....**4:30 P.M.**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....**Feb 24, 1945** to.....**July 13, 1945**  
and that I last saw him alive on.....**July 13, 1945**

Immediate cause of death.....**Carcinoma of liver**  
DURATION.....**6 mos**

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Antopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of Injury..... Injured at work?

23. SIGNATURE.....**Samuel M. Peyton M.D.**  
M. D. or other

Address.....**Crisfield Md** Date signed.....**July 15, 1945**

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
JUL 25 1945  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH



Reg. Dist. No. 265

07272

## 1. PLACE OF DEATH:

County.....Somerset

City or town.....Crisfield

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....Md County.....Somerset

City or town.....Crisfield

(If outside city or town limits, write RURAL and give nearest town)

Street No.....RED

(If rural, give LOCATION)

2.(a) If veteran, name war.....none

## 3. (a) FULL NAME

Robert James Sterling Sr.

## 3. (b) Social Security Number

none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widower

6.(b) Name of husband or wife.....Annie E.

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.).....April 7, 1864

8. AGE:	Years	Months	Days	It less than one day
81	3	10	hrs.	min.

9. Birthplace.....Crisfield, Md.  
(Town, county, and state)

10. Usual occupation.....waterman

11. Industry or business.....self

12. Name.....Robt. J. Sterling

13. Birthplace.....Md.

14. Maiden name.....Margaret Nelson

15. Birthplace.....Md.

16. Informant.....Miss Alda Sterling

Address.....RFD Crisfield

17. (Burial, cremation, or removal, Which?).....Burial Date thereof.....7/20/45  
(month) (day) (year)

Cemetery or crematory.....Asbury

Location.....Crisfield, Md.

18. Funeral director.....Howard H. Hubbard

Address.....306 Main St. Crisfield, Md.

19. (Date rec'd by registrar).....7/19/45.....C. E. Collins, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....July 17, 1945, at.....M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from.....June 28, 1945, to.....July 17, 1945.

and that I last saw him alive on.....July 17, 1945.

Immediate cause of death.....

DURATION

Chronic Nephrositis

General Arteriosclerosis

Due to.....

Other conditions.....Isolation

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Mean of injury..... Injured at work?

23. SIGNATURE.....

M. D. or other.....

Address.....

7/19-1945 Crisfield Md

RECEIVED

JUL 25 1945

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (193)

07273

## CERTIFICATE OF DEATH



Reg. Diat. No. 268

## 1. PLACE OF DEATH:

County SomersetCity or town Deal Island Md  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life timeHospital, institution, or street address where death occurred: -How long in hospital or institution? -

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County SomersetCity or town Deal Island  
(If outside city or town limits, write RURAL and give nearest town)Street No. -  
(If rural, give LOCATION)2(a) If veteran, name war -

## 3. (a) FULL NAME

Russell Webster

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Francis Webster7. Birth date of deceased (mo., day, yr.) Sept 23 - 1895-8. AGE: Years 50 Months - Days - If less than one day - hrs. - min. -9. Birthplace Deal Island Md  
(Town, county, and state)10. Usual occupation Janitor Deal Island A.S.

## 11. Industry or business

12. Name Benjamin Webster13. Birthplace Deal Island Md14. Maiden name Mary Webb Starnes15. Birthplace Deal Island Md16. Informant Wesley WebsterAddress Deal Island Md17. Burial Date thereof July 24-45  
(Burial, cremation, or removal? Which?) (month) (day) (year)Cemetery or crematory St Johns M.E. CemeteryLocation Deal Island Md18. Funeral director H. WebsterAddress Deal Island Md19. 7-28 19 45 Rosa Webster  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 21st 19 45, at 1000 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19and that I last saw him alive on 19Immediate cause of death Electrocuted (Accidental)

## DURATION

Due to -Due to -Other conditions -

(Include pregnancy within 8 months of death)

Major findings of operations -Date of op. -Autopsy results -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: Accidental Date of 7/21/45Accident, suicide, or homicide Accidental Date of 7/21/45Where did injury occur? Deal Island Somerset Md

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) School HouseMeans of injury Electricity Injured at work? No23. SIGNATURE Hugh L. Loutford, M.D.Address Prentiss Md M. D. or other -Date signed 7/22/45

RECEIVED  
AUG 7 1945  
PORTLAND V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-1

## CERTIFICATE OF DEATH

Reg. Dist. No. 17274 260

## 1. PLACE OF DEATH:

County... Somerset  
 City or town... Mt. Vernon, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Somerset  
 City or town... Mt. Vernon, Md  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. ....  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

William Williams

## 3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

M B Married

8. (b) Name of husband or wife Eugene Williams

7. Birth date of deceased (mo., day, yr.)

8. (c) If alive, give age years

8. AGE: Years Months Days If less than one day  
62 hrs. min.

9. Birthplace... South Carolina  
 (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant Julia Williams  
 Address Mt. Vernon, Md

17. Burial, cremation, or removal. Which? Burial Date thereof July 5, 1945  
 (month) (day) (year)

Cemetery or crematory St. Paul Cemetery

Location Mt. Vernon, Md

18. Funeral director Dale Bashell

Address Princess Anne, Md

19. July 5 45 R.A. Phares, Jr.  
 (Date read by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 3rd 19 45 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 to 19

and that I last saw him alive on 19

Immediate cause of death MyocarditisArteriosclerosis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

19. SIGNATURE R.A. Phares, Jr. M. D. or other

Address Princess Anne, Md Date signed 7/5/45

RECEIVED  
JUL 13 1945  
BUREAU V. B.